Joint Meeting of Health Planning Council and Health Planning Advisory Committee
May 20, 2014
One Ashburton Place
Matta Conference Room, 11th floor
Boston, MA
10:30 a.m. - 12:00 p.m.

Health Planning Council Members Present:
Cheryl Bartlett, Commissioner, Department of Public Health (DPH); Áron Boros, Executive Director, Center for Health Information and Analysis (CHIA); Thomas Concannon, Rand Corporation; Marcia Fowler, Commissioner, Department of Mental Health (DMH); Ann Hartstein, Secretary, Executive Office of Elder Affairs (EOEA); John Polanowicz, Chairperson, Secretary, Executive Office of Health and Human Services (EOHHS); David Seltz, Executive Director, Health Policy Commission (HPC).

Health Planning Advisory Committee Members Present:
Dana Bushell, Program Manager, Massachusetts Group Insurance Commission; Michael Hirsh, Acting Commissioner of Public Health, City of Worcester; Dr. Myechia Minter-Jordan, President and CEO, The Dimock Center; Mary Ann O'Connor, President and CEO of the VNA Care Network and Hospice; Lora Pellegrini, President and CEO, Massachusetts Association of Health Plans; Brian Rosman, Research Director, Health Care for All; Anne Whitman, President, Cole Mental Health Consumer Resource Center.

Secretary Polanowicz called the meeting to order at 10:30 a.m. He asked if there were any comments on the Minutes of the March 26 meeting. Secretary Hartstein noted that on page three her title was listed as Commissioner instead of Secretary. With that correction, the Secretary asked for a motion to approve the Minutes. After a motion made and seconded, the Minutes were approved unanimously.

Secretary Polanowicz then turned the meeting over to DPH Associate Commissioner Madeleine Biondolillo for the presentation. Dr. Biondolillo reviewed the agenda for the meeting and noted the date of the next meeting (July 9). She thanked the members for their prompt response to the inquiry regarding availability for that date. She reviewed the timeline for the work of the Council and Advisory Committee. She reviewed the analytic roadmap and framework for the report. She added that this meeting presents an opportunity for the Council and Advisory Committee members to communicate with the team that is working on the behavioral health data and analysis. She proceeded to present the inventory data, noting that the analysis uses the 15 Health Policy Commission regions.

During the presentation on Mental Health inventory and the comments on DMH roles, Dr. Biondolillo stressed that more than 90 percent of the DMH clients are served in the community. Commissioner Fowler noted that the 21,000 DMH clients listed on slide 9 do not include the 8-9,000 patients admitted for forensic evaluations.

Dr. Biondolillo reminded the Council and Advisory Committee members that part of the goal of this process is to build a framework for health planning. Not everything will fit perfectly into the framework, but it is important to bring forth the issues even if they do not fit.

Dr. Biondolillo commented that there are four mental health service groups (inpatient psychiatric beds, inpatient continuing care beds, and for outpatient: licensed mental health clinics and community based flexible support services) that we have data for now and that the inventory for additional services are being developed. Dr. Biondolillo noted that from 2010 to 2014, inpatient bed capacity has grown 5 percent among freestanding hospitals and 2 percent among all hospitals. General hospitals showed no change in bed capacity.

Regarding slide 13, licensed mental health clinics, where certain clinics were excluded, Dr. Concannon asked what the denominator of licensed clinics is. Secretary Polanowicz suggested it would be helpful to have a breakout of what is included and what is not included.

On slide 14, DMH Community Redesign, which began in 2009 and supports the Administration's Community First initiative, Secretary Polanowicz asked if Commissioner Fowler had a sense of where DMH was in 2009, compared to today providing 90 percent of services in the community. He noted that the number of beds is down and has been at 626 for a few years, and the number of people served has increased. Commissioner Fowler responded that there are approximately 100 people in the 626 continuing care beds who are awaiting community placements. Beth Lucas, DMH Director of Quality Improvement, commented that DMH has seen a decreased length of stay over several years, allowing DMH to serve more people in continuing care.

Regarding other mental health services listed on slide 15, Commissioner Fowler asked if clubhouses were going to be included in the data. The answer was yes, they are.

Reviewing slide 16, Inpatient Psychiatric Beds, Dr. Concannon noted the wide distribution among the regions of beds per 100,000 population. He asked, for example, what happens when someone is referred from the Berkshire region, which has one of the lower rates. Commissioner Fowler commented that inpatient utilization is linked to availability of diversionary and community-based services. Secretary Polanowicz added that this analysis is based on Massachusetts and does not account for those who go to centers outside of Massachusetts. He noted that for some of the data presented, a zero does not mean there is no access; it may be provided elsewhere in the community. Commissioner Fowler added that the average daily census is 18,500, but it is hard to quantify how a hospital is affected by other services in the community.

Mr. Rosman asked if the E. Merrimack and Attleboro regions, two regions with higher beds per 100,000 population, treat non-Massachusetts clients. The answer was yes, but those clients are not factored into the population numbers. Mr. Rosman responded that then perhaps those two areas are not as 'overbedded' as they appear in comparison to other regions.

Dr. Biondolillo asked for feedback on the map of inpatient psychiatric beds (slide 17), which shows the density of inpatient psychiatric beds by shades of blue as well as the location of all Massachusetts acute hospitals.

Mr. Rosman commented on distance, noting that Cape Cod is not 'dense' in terms of beds/100,000, and the distance from Provincetown to Cape Cod Hospital is significant. Dr. Biondolillo responded that the team will investigate means to overlay such information.

Commissioner Bartlett suggested breaking out the acute hospitals, indicating which provide psychiatric services, emergency departments without psychiatric units, etc., adding that emergency departments are a point of entry whether the patient stays at that hospital or not.

There was a discussion of the bullets at the bottom of slide 18 (Continuing Care Mental Health Services) indicating notable changes during 2011-13. Commissioner Fowler asked if this slide meant to reference Westborough State. Beth Lucas of DMH reported that Westborough closed in 2010. The bed reduction related to changes at Taunton and Worcester. She suggested that perhaps the order of the second and third bullets should be reversed.

Secretary Hartstein asked about the distinction between DMH consumers (the 21,000 DMH clients referred to earlier) and patients who receive psychiatric treatment. It was clarified that anyone admitted to a psychiatric unit is not necessarily a DMH client. Commissioner Fowler added that of the 73,000 admissions in acute psychiatric settings, approximately two percent are DMH clients.

On slide 20, DMH Community Based Flexible Support Services, Dr. Biondolillo noted that two areas (Upper North Shore and Metro West) look as if there are no services available. She noted that this is not the case. The residents of these regions are served through neighboring regions' site offices. She added that this is an example of contextualization that needs to be made clear and asked for suggestions on how to show this. Mr. Boros asked if, in this instance when the metric does not fit the region, one could combine the two regions. Secretary Polanowicz suggested an alternative would be to look at where the placements are. We can show where the capacity is actually located, but presented that way only shows a point in time. Commissioner Fowler added that this would be up to one thousand individual addresses representing people in their own apartments.

Lori Cavanaugh, from CHIA, noted that the Health Policy Commission has rolled their fifteen regions into eight regions and it is all zip code based. Mr. Seltz asked if both the fifteen and eight regions could be shown.

Dr. Concannon asked if the numerator is individual slots. Secretary Polanowicz responded that it is. Ms. Lucas added that each contract has a fixed capacity that can be served at any one given time. However, the services can be flexibly delivered where the person is living. Therefore, DMH cannot provide a capacity by HPC region as the location of the service varies depending on where the person served at the time is living. In this way, capacity quickly becomes utilization.

Commenting on the Health Policy Commission regions and the DMH site offices, Dr. Biondolillo noted that in thinking about how data will be collected going forward it makes sense to initiate a behavioral health data users' work group, which will be mentioned later in the presentation.

For slide 23, Changes in Inpatient Psychiatric Beds 2010-2014, Commissioner Bartlett asked about the state-operated beds. Commissioner Fowler responded that there are two state-operated acute-care units operated in community mental health centers, one in Pocasset, one in Fall River. Commissioner Fowler also reported that approximately 200 beds will be added in the next year. Mr. Rosman suggested that this slide separate out the adult and child beds.

Overall, freestanding beds have increased 5 percent over that last four years while there has been no growth for general acute hospital psychiatric beds. The closures happened before 2010. Commissioner Fowler noted that the freestanding facilities have less overhead cost and risk adjustment issues than general hospitals, which may impact this trend.

The presentation then moved on to the substance abuse portion of the Inventory. It was noted that, just as with mental health services, some of the general hospitals and outpatient clinics licensed by the Division of Health Care Quality also provide substance abuse treatment services. As indicated on slide 27, Substance Abuse Service Inventory, not all of the services have been formally inventoried yet.

Secretary Polanowicz asked when the new beds created through the legislatively established Substance Abuse Trust Fund to expand treatment capacity would be coming on line. Commissioner Bartlett noted that the beds are on line. Lydie Ultimo, Deputy Director of the Bureau of Substance Abuse Services, commented that the expansion was completed in April, 2014. The data in the presentation is as of March 21, 2014. 80 additional beds were added through this expansion process after March 21, 2014. As such, on slide 28, the total count of 2,341 residential beds does not include 40 of the new residential beds. Likewise the total count of 291 TSS beds does not include 40 new TSS beds.

On slide 31, it was noted that gender breakdown is an important planning issue. Secretary Hartstein asked if the capacity to service 117 families in residences were short-term placements. The answer was yes.

Regarding Outpatient Care (slide 32), it was noted that BSAS funds 14 office-based opioid treatment (OBOT) programs; less information is available about non-BSAS-funded programs.

It was noted that among the Opioid Overdose Intervention programs (slide 33) Learn to Cope, which is one program that has 12 sites, provides a variety of services including Naloxone distribution.

Secretary Polanowicz asked if the 20 beds in the Metro Boston region in the Acute Inpatient Medically Managed Substance Abuse Services (slide 36) included the Faulkner beds, adding that it looked like St. Elizabeth Medical Center's and Faulkner Hospital's beds were included.

Commissioner Bartlett asked about the different numbers presented for the total Massachusetts population. It was clarified that the population that is used for the substance abuse data is thirteen years of age or older; the population used in the DMH data included all ages.

The map of Inpatient and other Acute Substance Abuse Services (slide 39) shows the density of beds through the shading of the color blue for each region. The map does not include Section 35 beds. In addition, all acute hospitals are shown because people receive services related to substance abuse in acute hospitals. Ms. Ultimo commented that rolling up the regions from 15 into 8 may better reflect the availability of services in the New Bedford/Fall River area. Using 15 regions, it looks like there are no services available in the New Bedford region. She added that this is a statewide system.

Secretary Polanowicz commented that mental health system seems more like a statewide system; substance abuse services feel more local. He asked the group if that sense was accurate. The response was that it depends on the level of care. In the discussion that followed, Dr. Minter-Jordan commented that her organization serves 200 zip codes for detox services. Ms. Bushell commented that the Group Insurance Commission sees a lot of people going out of state/out of network for substance abuse services. There are several reasons for this including the stigma associated with medication management and removal from a community to break the connection of the environment.

Lora Pellegrini noted that this issue deserves attention regarding best practices and the importance of understanding the continuum of care. If the next step in the continuum of care is not available, relapse is higher. Secretary Polanowicz agreed that one needs a solid plan of care post-detoxification or you are setting the client up for recidivism.

Dr. Concannon commented that through this discussion he was hearing that there is a wide variety of care, a lot of which is happening out of state, but for some it is better to be near family support. He suggested that utilization data would be more useful than capacity data.

After reviewing the points for consideration (slides 43-44), Dr. Biondolillo reminded the group that through this process we are building a framework. Going forward we will work to fill in the gaps. She was pleased to announce that in order to align data and improve reporting an interagency behavioral health data users' work group will be convened this year. Dr. Biondolillo thanked both DMH and BSAS staff for the time they have spent working to provide this information. She added that we want to maintain the momentum and consider going forward how we should be acquiring information. Secretary Polanowicz recommended that CHIA and the HPC, who are working with data across state systems, be represented on this work group. Dr. Biondolillo responded that they are included.

Mr. Boros summarized the challenges:

1) Aligning data;
2) Improving reporting;
3) Linking data; and
4) Hosting the data in one place.

The group reviewed the sample Data Tables (slides 49-52) that represent one way of looking at the data. They would be repeated for the three payor sources of data. Richard Dougherty, DMA Health Strategies, noted that these tables show inpatient and outpatient data, but intermediate levels of care can also be presented where the data are available.

Dr. Biondolillo then asked the group how these data could be helpful to them. She reviewed the data challenges (slide 53).

Dr. Minter-Jordan noted that she did not see information presented about disparities. Dr. Biondolillo responded that the group is committed to breaking out this information where they can.

Dr. Concannon asked if this represented the desired set of cross tabulations, adding that there are many more ways of presenting data. Dr. Biondolillo responded that she is looking for the group's feedback. Mr. Dougherty added that this was his take on the desired direction, with a goal of getting as close as possible. Ms. Lucas added that the work group knew the initial set of data will produce more questions.

Commissioner Fowler referred back to slide 5, and asked about the distinction between need and demand. Mr. Dougherty responded that they do not have a data set for demand, but we know there is something in between prevalence and use. Dr. Biondolillo added that it is a conceptual framework for the data. Secretary Polanowicz commented that we are trying to create a framework that within this construct might work for demand for other domains. The methodology may be improved, but the intent is to use a consistent approach that maintains fidelity to the framework for health planning. We do not want to use a different approach with each domain.

Dr. Biondolillo then reviewed the summary of findings from the Request for Information released in January 2014 and surveys conducted in March and April. This information, including the five common concerns (slide 58), will be included in the report.

Dr. Biondolillo reviewed the resources that have been used in the interagency collaboration to support health planning, noting that the EOHHS and DPH are committed to moving the process forward. She stated that the next domains to be addressed are Post-Acute Care, PCI and Trauma, and added that Post-Acute Care will be an expansive domain.

Ms. Pellegrini complimented the work of the health planning work group. She asked how the stakeholder input will be used. She noted the importance of having data to support the assertions made.

Dr. Biondolillo reviewed the next steps (slide 60). She noted that Issue Briefs will include high level summary of areas.

The next meeting will be July 9. The meeting adjourned at 12:02 p.m.